HELP US GET TO KNOW YOU

NAME:_____

For children, please fill out highlighted areas only

How did you hear about us or who referred you to our office?_____

Previous dentist _____

Last dental cleaning _____

Dental concerns _____

Would you say your current DENTAL health is : Good Fair Poor

How healthy do you want your mouth: Perfect Good Fair

Level of dental fear 1 2 3 4 5 6 7 8 9 10

What sort of dental work have you had in the past? (circle all that apply)

Cleaning fillings crowns extraction orthodontic (braces)
root canal implants gum treatment partial/denture surgery

Have you ever had any bad reactions to any previous dental treatment? Y N

Do you like your smile? Y N

Do you drink carbonated beverages? Y N

If yes, what kind_____, how much_____ /day

Do you experience pain or discomfort in your jaw joint (TMJ) Y N

Have you ever had/ or have an eating disorder- Bulimia & Anorexia (circle which)? Y N

Do you use tobacco? Y N

If yes, what kind_____, how much_____ and for how long_____

If YES, do you still use tobacco? Y N

Do you have a personal or family history of oral cancer? Y N

Do you feel like your mouth is dry throughout the day or night? Y N

Do you grind your teeth or have you been told you grind your teeth? Y N

Do you have (or did you have) a thumb or finger sucking habit? Y N

Do you require antibiotics before dental treatment? Y N

Does your breath concern you? Y N

Do your gums ever bleed? Y N

Do you have sensitive teeth? Y N

How often do you brush? _____ x day or if not daily, _____ x week

Type of brush? Manual Sonicare Oral B Braun Other_____

What type of toothpaste? Crest Colgate Other_____

How often do you floss? _____ x day or if not daily _____ x weekor_____ x month

Mouthwash? Crest ProHealth Listerine Fluoride rinse

Other_____